Prompt Payment Reporting Manual

Kentucky Department of Insurance
Division of Health Insurance Policy and Managed Care

Instructions for Submission of Prompt Payment Report

Beginning with the third quarter of 2002, each insurer which offers health benefit plans in Kentucky shall file a report with the Kentucky Department of Insurance which includes the following information:

(a) The number of clean claims received by the insurer, its agent, or designee during the reporting quarter;

(b) The percentage of clean claims received by the insurer, its agent, or designee that were:
   1. Adjudicated within the claims payment time frame;
   2. Adjudicated within one (1) to thirty (30) days from the end of the claims payment time frame;
   3. Adjudicated within thirty-one (31) to sixty (60) days from the end of the claims payment time frame;
   4. Adjudicated within sixty-one (61) to ninety (90) days from the end of the claims payment time frame;
   5. Adjudicated more than ninety (90) days from the end of the claims payment time frame; and
   6. Not yet adjudicated;

(c) The percentage of clean claims received during the reporting quarter that were paid and not denied or contested;
   1. Within the claims payment time frame;
   2. Within one (1) to thirty (30) days from the end of the claims payment time frame;
   3. Within thirty-one (31) to sixty (60) days from the end of the claims payment time frame;
   4. Within sixty-one (61) to ninety (90) days from the end of the claims payment time frame; and
   5. More than ninety (90) days from the end of the claims payment time frame.

(d) Amount of interest paid; and

(e) For clean claims received during the reporting quarter that were not denied or contested, the percentage of the total dollar amount of those claims that were paid within the claims payment time frame.

Each insurer is required to submit the above data for hospitals, physicians, and all other providers (excluding pharmacy) to demonstrate compliance with KRS 304.17A-722 (2).

Terms, including adjudicate, clean claim, claims payment time frame, contested claim, and provider, are defined in 806 KAR 17:310, Section 1.

Data must be reported electronically on a 3.5-inch diskette, CD ROM, or Zip disk, and labeled with the company name, name of report, and reporting quarter. The data must be submitted in a Microsoft Excel spreadsheet and include the following:

- Sheet One (1)- Insurer Identification Information. On this sheet, you will report information relating to your company using alpha numeric values; and
- Sheet Two (2)- Prompt Payment Data. On this sheet, you will report information relating to the payment of claims using numeric values.

All numeric fields must be completed If there is no data to report for a specific numeric field, zeros shall be used.
A dollar amount must be expressed by using a decimal (.) and carried out two (2) places.
A percentage must be expressed using a number that is carried out two (2) decimal places.

Data submitted to comply with KRS 304.17A-722, shall not be considered complete unless accompanied by a HIPMC-CP-2, the Affidavit, as incorporated by reference in 806 KAR 17:310.

Insurer Identification Information.
Prompt Payment Report - Sheet One (1)

This information which provides basic identifying information regarding the insurer shall be submitted as Sheet One (1) of the Excel spreadsheet submitted to meet reporting requirements of KRS 304.17A-722 (1). In the development of Sheet One (1), include the field description and valid values in the respective row and column as listed in the chart. The information you report in Column A should be identical to information reported in Column A below. The information you report in Column B should be reported as described in Column B below .

Row		***Column A***		***Column B***
1	**Row/ Column**	**Field Description**	**Row/ Column**	**Valid Values**
2	2/A	Insurer Name	2/B	Alpha-numeric, maximum 150 characters
3	3/A	DBA Name	3/B	Alpha-numeric, maximum 150 characters
4	4/A	Reporting Quarter	4/B	Must be numeric. This is the 4 digit (month and year) reporting quarter.
5	5/A	Contact person	5/B	Alpha-numeric, maximum 150 characters
6	6/A	Insurer's telephone number	6/B	Must be 10 digits numeric (do not include dashes, etc)
7	7/A	First line of mailing address	7/B	Alpha-numeric, maximum 150 characters
8	8/A	Second line of mailing address	8/B	Alpha-numeric, maximum 150 characters
9	9/A	City	9/B	Alpha-numeric, maximum 150 characters
10	10/A	State	10/B	Must be 2 digits alphabetic
11	11/A	Zip code	11/B	Must be 5 or 9 digits numeric (do not include dashes, etc.)
12	12/A	NAIC number	12/B	Must be numeric.
13	13/A	NAIC group number	13/B	Must be numeric.
14	14/A	Federal tax ID number	14/B	Must be 9 digits numeric (do not include dashes, etc.)
15	15/A	For clean claims received during the reporting quarter that were not denied or contested, the percentage of the total dollar amount of those claims that were paid within the claims payment time frame for all claims (excluding pharmacy).	15/B	Must be expressed using a number that is carried out two (2) decimal places.

Prompt Payment Data
Prompt Payment Report - Sheet Two (2)

This information as required by KRS 304.17A-722 (1) shall be submitted as Sheet Two (2) of the Excel spreadsheet. In the development of this report, you should include the field description and valid value in the respective row and column as listed in the chart. The information you report in Column A should be identical to information reported in Column A below. The information you report in Columns B, C, and D should reflect the information required for the provider (s) identified in the specified header (s).

Row	*Column A*	*Column B*	*Column C*	*Column D*
1	**Description**	**Hospital**	**Physician**	**All other providers excluding pharmacy**
2	Number of Clean Claims received by the insurer, its agent, or designee during the reporting quarter.	B2	C2	D2
3	Percentage of Clean Claims received by the insurer, its agent, or designee that were adjudicated within claims payment time frame.	B3	C3	D3
4	Percentage of Clean Claims received by the insurer, its agent, or designee that were adjudicated one (1) to thirty (30) days after claims payment time frame.	B4	C4	D4
5	Percentage of Clean Claims received by the insurer, its agent, or designee that were adjudicated thirty (31) to sixty (60) days after claims payment time frame.	B5	C5	D5
6	Percentage of Clean Claims received by the insurer, its agent, or designee that were adjudicated sixty-one (61) to ninety (90) days after claims payment time frame.	B6	C6	D6
7	Percentage of Clean Claims received by the insurer, its agent, or designee that were adjudicated more than ninety (90) days after claims payment time frame.	B7	C7	D7
8	Percentage of Clean Claims received by the insurer, its agent, or designee that were not yet adjudicated.	B8	C8	D8
9	Percentage of Clean Claims received during the reporting quarter that were paid and not denied or contested within the claims payment time frame.	B9	C9	D9
10	Percentage of Clean Claims received during the reporting quarter that were paid and not denied or contested within one (1) to thirty (30) days from the end of the claims payment time frame.	B10	C10	D10
11	Percentage of Clean Claims received during the reporting quarter that were paid and not denied or contested within thirty-one (31) to sixty (60) days from the end of the claims payment time frame.	B11	C11	D11
12	Percentage of Clean Claims received during the reporting quarter that were paid and not denied or contested within sixty-one (61) to ninety (90) days from the end of the claims payment time frame.	B12	C12	D12
13	Percentage of Clean Claims received during the reporting quarter that were paid and not denied or contested more than ninety (90) days from the end of the claims payment time frame.	B13	C13	D13
14	Amount of interest paid	B14	C14	D14
15	For Clean Claims received during the reporting quarter that were not denied or contested, the percentage of the total dollar amount of those claims that were paid within the claims payment time frame.	B15	C15	D15